DR. R. WILLIAMS

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04300

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: ALLEGANY · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND · COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. · LENGTH OF STAY (in this place): Inf. & 28m	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 54 MARION STREET

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LEWIS	Victor	ALDERTON	5	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	7-19-96	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CELANESE Corp of America	POLICEMAN	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALDERTON, JOHN	SLIDER, CATHERINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	214-05-7340	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	15 yrs
	(c)	

331
82a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	Cumb.	Allegany	Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐	Not While At work ☐	HOW DID INJURY OCCUR?
—			m.			—

22. I hereby certify that I attended the deceased from 1/15/47, 19....., to 5/19/49, 19....., that I last saw the deceased alive on 5/19/49, 19....., and that death occurred at 6:28P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. R. Williams	M.D.	Cumberland	5/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 22, 1949	Hillcrest Burial Park	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 21, 1949	Winter R. Lantz, M.D.	John J. Hoffee	Cumberland, Md.

VS. A15

RECEIVED
MAY 25 1949
BUREAU Y. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04301

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 50 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2I3 Carroll St.	STREET ADDRESS (If rural, give location) 2I3 Carroll St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Harry W. Ambrose			4. DATE OF DEATH (Month) (Day) (Year) May 2, 1949		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 25, 1883	9. AGE last birthday 65 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Retired		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R	11. BIRTHPLACE (State or foreign country) Great Ca Capon, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Peter Ambrose			14. MOTHER'S MAIDEN NAME Maria Whisner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 705-07-8660	17. INFORMANT Wife same Address		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 hr.
Antecedent cause(s)	(b) Arteriosclerosis	10 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertension	5 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic Bronchitis with Asthma	10 yrs

331
830

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949, to 5-2, 1949, that I last saw the deceased alive on 4.20, 1949, and that death occurred at 29 m., from the causes and on the date stated above.

SIGNATURE H W Eliason MD (Degree or title) ADDRESS 126 Union St Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 5, 1949	NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. May 4, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR James F. Scarpelli	ADDRESS Cumberland, Md.

RECEIVED
MAY 10 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04302

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 5 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Frost Av.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 21 Frost Av.

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Elizabeth (Last) Bachman

4. DATE OF DEATH: (Month) 5 (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 3-3-1866

9. AGE last birthday: 83 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vincent Raley

14. MOTHER'S MAIDEN NAME: Mary Ann Deering

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Nell Raley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: mar 11 1949

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditione contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 11, 1949, to May 24, 1949, that I last saw the deceased alive on May 24, 1949, and that death occurred at 4:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W C Lane MD Frostburg Md 5-26-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 5-27-49

NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery

LOCATION (City, town or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG. 5-27-49

REGISTRAR'S SIGNATURE: Mrs Stanley K. Roe

24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md

VS. A15

RECEIVED
MAY 31 1949
BUREAU OF S.

Within corporate limits: Yes

04303

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 314 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midland
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Ann (Last) Bryson

4. DATE OF DEATH: (Month) May (Day) 12 (Year) 1949

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 28, 1894

9. AGE last birthday: 54 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone operator

10b. KIND OF BUSINESS OR INDUSTRY: Bell Tel. Co.

11. BIRTHPLACE (State or foreign country): Midlothian, Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Bryson

14. MOTHER'S MAIDEN NAME: Sarah Ann Prentice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 169-03-1623

17. INFORMANT: Susan Bryson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Failure	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of cervix generalized	6-8 mo.
171 48a	(c) abdominal carcinomatosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949 to May 12, 1949, that I last saw the deceased alive on May 11, 1949, and that death occurred at 8:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Thos A. Dyer, M.D. — ADDRESS: 247 Virginia Ave. — DATE SIGNED: 5/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 14, 1949 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG.: May 13, 1949 — REGISTRAR'S SIGNATURE: Winter K. Kautz M.D.

24. FUNERAL DIRECTOR: John J. Hofer — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04304

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland; LENGTH OF STAY (In this place) 6 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Rebecca; (Middle) V.; (Last) Buckalew

4. DATE OF DEATH: (Month) May; (Day) 5; (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept 28 1867

9. AGE last birthday: 81 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Va. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Buckalew

14. MOTHER'S MAIDEN NAME: Lydia Heckert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): /

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Nettie Cutter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443 / 462

Immediate cause (1) Congestive Heart Failure from

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive arteriosclerotic Cardio Vascular disease and (2) Cardiac arrhythmia

Malignancy of Colon & metastasis to entire body

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NO

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1949, to 5/5, 1949, that I last saw the deceased alive on 5/5, 1949, and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Eugene Frye, M.D. Lonaconing Md 5/12/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: May 8 1949

NAME OF CEMETERY OR CREMATORY: Buckalew Cemetery

LOCATION (City, town, or county) (State): Terra Alta W. Va

DATE RECD BY LOCAL REG. 5/8/49

REGISTRAR'S SIGNATURE: Jeannette M. Boal

24. FUNERAL DIRECTOR: M. Eichhorn, Lonaconing Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

04305

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 30 Yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 Virginia Ave.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 110 Virginia Ave.

3. NAME OF DECEASED (Type or Print)	(First) Martha C.	(Middle)	(Last) Boyer	4. DATE OF DEATH	(Month) May	(Day) 14,	(Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 26, 1876	9. AGE last birthday 72 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pendleton County W.Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ruben Kesner		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Noah W. Bower 110 Virginia Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac decompensation	Several Years
434.3 Antecedent cause(s)		
95c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 3, 1949, to May 14, 1949, that I last saw the deceased alive on May 14, 1949, and that death occurred at 4 35 m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John A. Dyer, M.D.	247 Virginia Ave.	May 14, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/16/49	Zion Memorial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 16, 1949	Walter K. Lantz, M.D.	James F. Scarpelli	Cumberland, Md.

VS. A15

RECEIVED
MAY 25 1949
BUREAU V. S.

Outside of City Limits

M

04306

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH · COUNTY: Allegany · STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Cumberland, Rural · LENGTH OF STAY (In this place): 2 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D. #3 Bowmans Addition Box 535

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. · COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Cumberland Rural
STREET ADDRESS (If rural, give location): R.F.D. #3 Bowmans Addition Box 535

3. NAME OF DECEASED (Type or Print): (First) Katherine Pearl (Middle) Robinette (Last) Brewster

4. DATE OF DEATH: (Month) May (Day) 25 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Oct. 26-1930

9. AGE last birthday: 18 yrs. · If under 1 year: Months / Days · If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Ridgely W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gilbert Robinette

14. MOTHER'S MAIDEN NAME: Leona Stewart.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Thomas Brewster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intrathoracic hemorrhage due to a rupture	at
Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underiying cause last	(b) of the left subclavian artery due to a 22	once
981 166	(c) gauge rifle wound in neck.	

II. OTHER SIGNIFICANT CONDITIONS
Cnnditions contributing tn the death but nnt reiated to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: home

near (CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): May 25/49 3.30 P. m.

INJURY OCCURRED While at work ☐ Nnt while at work ☒

HOW DID INJURY OCCUR?: Shot in the neck by her brother-in-law

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. May 26-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial · DATE THEREOF: 5/28/49 · NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park · LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 28, 1949 · REGISTRAR'S SIGNATURE: Walter L. Frantz. M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hofer, Cumberland, Md.

VS. A15A

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits

04307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 45 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 209 Humbird St	STREET ADDRESS (If rural, give location) 209 Humbird Street

3. NAME OF DECEASED (Type or Print)	(First) Henry	(Middle) Casper	(Last) Brinkman	4. DATE OF DEATH	(Month) May	(Day) 8	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov 24, 1882	9. AGE last birthday 66 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer	10b. KIND OF BUSINESS OR INDUSTRY B&O RR.	11. BIRTHPLACE (State or foreign country) Kalida, Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry C. Brinkman	14. MOTHER'S MAIDEN NAME Carolyn Foppe						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 705-07-7029	17. INFORMANT Mrs. Henry C. Brinkman					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma Prostate	3 years.
177 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
51	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1949, to May 8, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	[illegible]	Cumberland Maryland	May 10. 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/11/49	St. Mary's Burial Park	Cumberland, Allegany CO., Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 11, 1949	Winter R. Lantz, M.D.	John J. Hofer	Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1949
BUREAU V. S.

Within corporate limits

Dr. R. Williams

01308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 Wempe Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 23 Wempe Drive

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) Erven (Last) Brown

4. DATE OF DEATH (Month) May (Day) 4, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH Aug. 6, 1881

9. AGE last birthday 67 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector

10b. KIND OF BUSINESS OR INDUSTRY Steel Co.

11. BIRTHPLACE (State or foreign country) Front Royal, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John W. Brown

14. MOTHER'S MAIDEN NAME Eliza Moomah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Abbie Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
	(c) —	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from 1/10/49, 19..., to 5/4/49, 19..., that I last saw the deceased alive on 5/3/49, 19..., and that death occurred at 12 m., from the causes and on the date stated above.

SIGNATURE W. R. Williams (Degree or title) M.D. ADDRESS Cumberland, Md DATE SIGNED 5/5/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF May 7, 1949 | NAME OF CEMETERY OR CREMATORY Davis Memorial Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. May 5, 1949 | REGISTRAR'S SIGNATURE Winter R. Lantz M.D. | 24. FUNERAL DIRECTOR Charles L. George | ADDRESS Cumberland, Md.

VS. A15

Mr. Berge —

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limits

04309

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural — Ridgeley
STREET ADDRESS (If rural, give location): R.F.D. 1

3. NAME OF DECEASED (Type or Print): (First) Charles | (Middle) W. | (Last) Burkhart Jr.

4. DATE OF DEATH: (Month) May | (Day) 6 | (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Jan. 23-1940

9. AGE last birthday: 9 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Burkhart Sr.

14. MOTHER'S MAIDEN NAME: Mary Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Record

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 **Immediate cause** (a) Cerebral edema (marked) due to a severe — INTERVAL BETWEEN ONSET AND DEATH: 22 days

910c **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) concussion of the brain, due to being hit

(c) by an automobile

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: highway | (CITY OR TOWN): Wiley Ford | (COUNTY): Mineral | (STATE): W.Va.

TIME OF INJURY (Month) (Day) (Year) (Hour): Apr. 14/49-6 P m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR?: Ran down bank in front of automobile

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H.V.Deming M.D. | ADDRESS: Cumberland Md. | DATE SIGNED: May 8-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: May 9, 1949 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: May 8, 1949 | REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D. | 24. FUNERAL DIRECTOR: Charles L. George | ADDRESS: Cumberland, Md.

RECEIVED
MAY 17 19[illegible]
BUREAU [illegible]

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04310

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; MARYLAND; LENGTH OF STAY (in this place) 4 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 106 ALTAMONT TERRACE

3. NAME OF DECEASED (Type or Print): (First) BABY GIRL (Middle) (Last) CAGE

4. DATE OF DEATH: (Month) 5 (Day) 27 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 5-23-49

9. AGE last birthday: ... yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT CAGE

14. MOTHER'S MAIDEN NAME: ANN COTTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) atelectasis

(c)

7625
159

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Page Hodges, M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION | DATE THEREOF 5-29-49 | NAME OF CEMETERY OR CREMATORY MEMORIAL HOSPITAL | LOCATION (City, town, or county) CUMBERLAND, ALLEG. (State) MD

DATE REC'D BY LOCAL REG. May 29, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Memorial Hospital ADDRESS Cumberland, Md.

VS. A15

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Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04311

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 72Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Pennsylvania Ave	STREET ADDRESS (If rural, give location) 20 Pennsylvania Ave

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Minnie (Last) Campbell				4. DATE OF DEATH (Month) May (Day) 8, (Year) 1949 19	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH May 1, 1872	9. AGE last birthday 77 yrs.	If under 1 year Months. Days. If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Riley			14. MOTHER'S MAIDEN NAME Mary Biggerstaff		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. G. Jenn I. Campbell Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis — Not known

422.2

Antecedent cause(s)

93e

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 24, 1949 to May 5, 1949, that I last saw the deceased alive on May 5, 1949, and that death occurred at 6 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Johnson Jr.	M.D.	Cumberland Md	5-9-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 10, 1949	Rose Hill Cem	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 9, 1949	Winter R. Frantz M.D.	James F. Scarpelli	Cumberland, Md.

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MAY 17 1949
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Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04312

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 91 yrs.
HOSPITAL OR INSTITUTION, OR STREET ADDRESS 329 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 329 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Catherine (Last) Eaton

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1858

9. AGE last birthday: 91 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse.

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: Robert Eaton

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk — (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Robert A. Daugherty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 — Immediate cause (a) Myocarditis — Interval between onset and death: 10 years

930 — Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 24, 1949, to May 2, 1949, that I last saw the deceased alive on April 24, 1949, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE J. T. Johnson Jr (Degree or title) M.D. — ADDRESS Cumberland Md — DATE SIGNED 5-2-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF May 4, 49 — NAME OF CEMETERY OR CREMATORY St. Peter & Paul — LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REG. May 3, 1949 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limit F. T. Cawley

04313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) 232 North Mechanic Street

3. NAME OF DECEASED (Type or Print)	(First) Maude	(Middle) B.	(Last) Clem	4. DATE OF DEATH	(Month) May	(Day) 1	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-5-94	9. AGE last birthday 54 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Crabtree		14. MOTHER'S MAIDEN NAME Emma Zimmerla	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Memorial Hospital, Cumberland, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma Of Cervix	2 yrs.
171 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
480	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March, 1947, to May, 1949, that I last saw the deceased alive on April 30, 1949, and that death occurred at 7:10 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank Cawley	M.D.	Memorial Hospital Cumberland Md.	May 2, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/4/49	NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery	LOCATION (City, town, or county) Keyser, W. Va (State)
DATE REC'D BY LOCAL REG. May 4, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04314

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (In this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WEST VIRGINIA COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MAYSVILLE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
BABY	GIRL	COSNER	MAY	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	Single	MAY 8, 1949	yrs.		1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MELVIN COSNER
14. MOTHER'S MAIDEN NAME: DORA BOOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: 1 day

Immediate cause (a) Prematurity

776 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

159 (b) Mother had ruptured appendix & gen. peritonitis 3 days

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1949 to May 9, 1949, that I last saw the deceased alive on May 9, 1949 and that death occurred at ____ p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Wayne Hodges, M.D. May 10, 1949.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-10-49	Cosner Cemetery	Bismark, Grant Co. W. Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-10-49	Hunter R. Trout, M.D.	Melvin Cosner (Father)	Maysville, W. Va

VS. A15

RECEIVED
MAY 17 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04315

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Allegany — MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland LENGTH OF STAY (in this place) 53 yrs HOSPITAL OR INSTITUTION OR STREET ADDRESS 400 Race St.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md — COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural, give location) 400 Race St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ruby	Pearl	Deneen	May	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Widowed	July 26, 1885	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Rural near Cumberland, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hanson F. Kimble	Mary V. Wentling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	John Cozad

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	Unknown
	(c) Senile Psychosis	Unknown

252.1
630

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7/7/48, 19..., to 8/21/48, 19..., that I last saw the deceased alive on 5/21/49, 19..., and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE J. Lee Sm[illegible] (Degree or title) ADDRESS 40 Decatur St DATE SIGNED 5/21/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 21, 1949	Rose Hill Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 21, 1949	Wm. R. Franz, M.D.	John J. Hafer	Cumberland, Md.

VS. A15

RECEIVED
MAY 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

104316

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 88 Yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 616 Washington St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Susan (Last) Dixon

4. DATE OF DEATH: (Month) May (Day) 2 (Year) -49 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 24, 1861

9. AGE last birthday: 88 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lewis A Miller

14. MOTHER'S MAIDEN NAME: Margaret O'Donnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ellen M. Dixon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myocardial Failure — Interval Between Onset and Death: 8 hrs

Antecedent cause(s) 422.2 93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis — 3 mo.

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1947, to May 3, 1949, that I last saw the deceased alive on May 2, 1949, and that death occurred at 1:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M. D. 110 S. Centre St. May 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 5-5-49

NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul

LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: May 4, 1949

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: John C Holford

ADDRESS: Cumberland, Md.

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limits: DR. WHITWORTH
Evidence for addition of 18c shown on:

FILM No. G 120 JUL -5 1949

04317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~RT # 1 HOMEWOOD, ADD.~~ Cumberland
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CUMBERLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RT # 1 CUMBERLAND, Rural
STREET ADDRESS (If rural, give location) HOMEWOOD ADDITION

3. NAME OF DECEASED (Type or Print) (First) LOUISE (Middle) B. (Last) DORSEY
4. DATE OF DEATH (Month) may (Day) 11 (Year) 1949
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH Sept 27-1905
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JACK POLLOCK
14. MOTHER'S MAIDEN NAME LILLIAN BLANK.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Benjamin Dorsey.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure
155
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CARCINOMATOSIS Generalized
46+
(c) Primary Carcinoma of Liver —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION MAY 10
19b. MAJOR FINDINGS OF OPERATION Generalized Carcinomatosis Chest & Abdomen.
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 May, 1949, to 11 May 1949, that I last saw the deceased alive on 11 May, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Fuller B. Whitworth (Degree or title) M.D. ADDRESS 112 Bedford St. Cumb. Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify) Burial
DATE THEREOF May 14-49
NAME OF CEMETERY OR CREMATORY St Georges Episcopal Cem.
LOCATION (City, town, or county) Mt Savage (State) Md.

DATE REC'D BY LOCAL REG. May 13, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer. ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 T

RECEIVED
MAY 17 1949
BUREAU V. S.

Within corporate limits

04318

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highway, Cumberland
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cor. Beall & Spruce St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 528 Green St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) J. (Last) Edmondson
4. DATE OF DEATH (Month) May (Day) 22 (Year) 1949
5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Nov. 24-1933
9. AGE last birthday 15 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Earnest Yates
14. MOTHER'S MAIDEN NAME Carrie Edmondson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ------
17. INFORMANT Uncle Percy H. Edmondson.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH at once

Immediate cause (a) Subdural hemorrhage & contusion of the brain

813.5

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to a fracture of the skull

170c

(c) Riding a bicycle, hit by an automobile.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ & CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) May (Day) 22 (Year) 1949 (Hour) 8 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Riding a bicycle, hit by an automobile

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED May 23-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 25, 49
NAME OF CEMETERY OR CREMATORY Summer Cem.
LOCATION (City, town, or county) Cumberland (State) Md.
DATE REC'D BY LOCAL REG. May 25, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 1 1949
BUREAU V. P.

04319

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 36 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 106 W. Loo St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 106 W. Loo St.

3. NAME OF DECEASED (Type or Print) (First) Louis (Middle) (Last) Edmunds

4. DATE OF DEATH (Month) 5 (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 1-27-1904
9. AGE last birthday 45 yrs. If under 1 year: Months 3, Days 11; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scale Specialist
10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.
11. BIRTHPLACE (State or foreign country) Glyn Neth, Whales
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Charles Edmunds
14. MOTHER'S MAIDEN NAME Annie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-5649
17. INFORMANT Mr Carl Spitznas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary heart attack (Thrombosis)	15 min
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1946, to May 8, 1949, that I last saw the deceased alive on 5/4, 1949, and that death occurred at 1:00 A.m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walters (Degree or title) M.D. ADDRESS Frostburg Md DATE SIGNED 5/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 5-10-1949
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, (State) Md

DATE REC'D BY LOCAL REG. 4-9-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 12 1949
BUREAU V. S.

Dr. Wolferman

04320

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg — LENGTH OF STAY (in this place): all his life	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location): 123 Ormond St.

3. NAME OF DECEASED (Type or Print)	(First) RICHARD	(Middle) E.	(Last) EICHORN	4. DATE OF DEATH	(Month) May (Day) 27 (Year) 1949
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced	8. DATE OF BIRTH: Oct. 7, 1913	9. AGE last birthday: 35 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Spinner	10b. KIND OF BUSINESS OR INDUSTRY: Celanese	11. BIRTHPLACE (State or foreign country): Frostburg, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Walter Eichorn 213-10-9687	14. MOTHER'S MAIDEN NAME: Nellie Thorpe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Walter Eichorn			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Multiple sclerosis — 10 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) same

345
87d

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1948, to May 28, 1949, that I last saw the deceased alive on May 27, 1949, and that death occurred at 7 30 p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ludolf Wolferman	M.D.	Frostburg	5-28-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-30-49	Allegany	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-30-49	Mr. Nancy N. Roe	Joseph R. Durst,	Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

RECEIVED
JUN 3 1949
BUREAU V. S.

DR. ENFIELD

Within corporate limits

04321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Evidence for addition of #21 is shown on: FILM No. G 121 JUL 15 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 86 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural, give location) REAR 725 COLUMBIA AVE.,

3. NAME OF DECEASED (Type or Print) (First) CATHERINE (Middle) (Last) EVERETT

4. DATE OF DEATH (Month) MAY (Day) 16 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH JAN. 19, 1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Phillip Metzger
14. MOTHER'S MAIDEN NAME Elizabeth Lapp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

904.0 Immediate cause (a) Myocarcial Insufficiency

186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fractured Hip.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Cumberland (COUNTY) (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 2/18/49 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fall (7/15/49 a.s.)

22. I hereby certify that I attended the deceased from Feb 18, 1949, to May 16, 1949, that I last saw the deceased alive on May 16, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE S. E. Enfield (Degree or title) ADDRESS Cumberland DATE SIGNED Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 18, 1949
NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. May 18, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, MD
24. FUNERAL DIRECTOR Charles L. George, " ADDRESS "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 T

RECEIVED
MAY 25 1949
BUREAU V. S.

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04322

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (in this place) 14 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 604 GREENE STREET

3. NAME OF DECEASED (Type or Print): (First) BART (Middle) J. (Last) FINAN

4. DATE OF DEATH: (Month) MAY (Day) 28 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: 7/19/71

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Ins.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: PATRICK FINAN

14. MOTHER'S MAIDEN NAME: CATHERINE NOONAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181 Immediate cause (a) Carcinoma of urinary bladder

528 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-13-, 1949, to 5-28-, 1949, that I last saw the deceased alive on 5-27-, 1949, and that death occurred at 3 a m., from the causes and on the date stated above.

SIGNATURE Howard L Tolson MD (Degree or title) ADDRESS DATE SIGNED 5-28-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: May 30, 1949

NAME OF CEMETERY OR CREMATORY: St. Patricks

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 29, 1949

REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

RECEIVED
JUN 6 1949
BUREAU V. S.

DR. WEISMAN

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04323

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near CUMBERLAND, Rural
STREET ADDRESS (If rural, give location) ROUTE # 3, VALLEY ROAD

3. NAME OF DECEASED (Type or Print): (First) ENOCH (Middle) (Last) FLEEK
4. DATE OF DEATH: (Month) MAY (Day) 27 (Year) 1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 6/11/1906
9. AGE last birthday: 42 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAVERN OWNER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ROBERT FLEEK
14. MOTHER'S MAIDEN NAME: CLARA WINTERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-10-4096
17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Myocardial Infarction due to — 5 days

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Occlusion — 5 days

(c) Hypertensive Cardiovascular Disease — ?

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: No (CITY OR TOWN) No (COUNTY) (STATE) No

TIME OF INJURY (Month) (Day) (Year) (Hour): No m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from May 23, 1949, to May 27, 1949, that I last saw the deceased alive on May 26, 1949, and that death occurred at 1" A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Harold G Weisman MD 122 Bedford St Cumberland, Md 5/27/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: May 29' 49
NAME OF CEMETERY OR CREMATORY: Eckhart Mem.
LOCATION (City, town, or county): Eckhart, (State) Md

DATE REC'D BY LOCAL REG.: May 29 49
REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc
ADDRESS: Cumberland Md

VS. A15

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

Evidence for change of age is on:

FILM No. G 120 MAY 20 1949

04324

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 54 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS I57 Thomas St.	STREET ADDRESS (If rural, give location) I57 Thomas St.

3. NAME OF DECEASED (Type or Print) (First) Nora Virginia (Middle) Giles (Last)			4. DATE OF DEATH (Month) May (Day) 4, (Year) 1949 19		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. I, I87I	9. AGE last birthday 77 ~~78~~ yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Romney, W.Va.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Mc Ilwee			14. MOTHER'S MAIDEN NAME Margaret Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None		17. INFORMANT Husband, Same address		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — 4 years

4222 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1945, to May 4, 1949, that I last saw the deceased alive on May 4, 1949, and that death occurred at 4:20 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] M.D. ADDRESS Cumberland Md. DATE SIGNED May 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 6, 1949	NAME OF CEMETERY OR CREMATORY Indian Mound Cem.	LOCATION (City, town, or county) (State) Romney W.Va.
DATE REC'D BY LOCAL REG. May 4, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, MD	24. FUNERAL DIRECTOR James F. Scarzelli	ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAY 10 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

04325

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: route3 Bedford Rd
LENGTH OF STAY (In this place): 82 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 3 Bedford Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 522 Bedford Rd.

3. NAME OF DECEASED (Type or Print): (First) Samuel Alexander (Middle) (Last) Gleichman

4. DATE OF DEATH: (Month) May (Day) 23 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 11-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P.O. Clerk,retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Mail

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John N.Gleichman

14. MOTHER'S MAIDEN NAME: Johanna Grampp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grace Gleichman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral embolus	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (2nd.stroke) arteriosclerosis	?
	(c)	

332
538

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming MD Cumberland Md. May 23-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 26,1949
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 26,1949
REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight Cumberland, Md.

VS. A15A

RECEIVED
JUN 1 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04326

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place) 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) State St.

3. NAME OF DECEASED (Type or Print): (First) Jacob; (Middle) William; (Last) Hadley

4. DATE OF DEATH: (Month) May; (Day) 18; (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 22 1868

9. AGE last birthday: 49 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): Lonaconing Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Harry Hadley

14. MOTHER'S MAIDEN NAME: Lottie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-2931

17. INFORMANT: Mrs Sara Hadley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive Heart failure —	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 443 932	(b) Hypertensive cardio-vascular	
	(c) disease & arrucular fibrillation	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —; PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —; (CITY OR TOWN) —; (COUNTY) —; (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1948, to 5/18, 1949, that I last saw the deceased alive on 5/17, 1949, and that death occurred at 12:15 P m., from the causes and on the date stated above.

SIGNATURE: Paul Eugene Frye (Degree or title) M.D ADDRESS Lonaconing Md. DATE SIGNED 5/20/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: May 21, 1949; NAME OF CEMETERY OR CREMATORY: Allegany Cemetery; LOCATION (City, town, or county): Frostburg; (State): Md.

DATE REC'D BY LOCAL REG. 5-21-49; REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rose; 24. FUNERAL DIRECTOR: W. E. Eichhorn; ADDRESS: Lonaconing Maryland

RECEIVED
MAY 23 1949
BUREAU V. S.

Within corporate limits

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04327

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 1HR. 28 MI.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 11 CRESAP ST.,

3. NAME OF DECEASED (Type or Print): (First) Nancy (Middle) BABY GIRL VIRGINIA (Last) Hall

4. DATE OF DEATH: (Month) MAY (Day) 16 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): NEW BORN

8. DATE OF BIRTH: MAY 16, 1949

9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours 1 / Min. 28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM HALL

14. MOTHER'S MAIDEN NAME: MARY NORRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

776 **Immediate cause** (a) Prematurity 6 mo

159 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Fuller B. Whitworth M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation | DATE THEREOF: May 18, 1949 | NAME OF CEMETERY OR CREMATORY: Memorial Hospital | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 18, 1949 | REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: Memorial Hosp. Cumberland

RECEIVED
MAY 25 1949
BUREAU V. S.

04328

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 55 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Emily Street.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) T (Last) HARTMAN

4. DATE OF DEATH: (Month) May (Day) 27, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 20, 1870

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter E. Hartman

14. MOTHER'S MAIDEN NAME: Mary Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Charles W. Hartman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure — 2 wks

422.2 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis — 2 yrs

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to May 27, 1949, that I last saw the deceased alive on May 25, 1949, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. — ADDRESS: 110 S. Centre St. Cumberland, Md. — DATE SIGNED: 5-27-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 29 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: May 29, 1949 — REGISTRAR'S SIGNATURE: Winter K. Kantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04329

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 524 Columbia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 524 Columbia Ave.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Wilbur (Last) Hartung

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Dec. 13-1888

9. AGE last birthday: 60 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman at Queen City

10b. KIND OF BUSINESS OR INDUSTRY: Glass Co.

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wolfgong Hartung

14. MOTHER'S MAIDEN NAME: Margaret Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-7857

17. INFORMANT: J.S.Kegg

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary sclerosis	?
	(c) also had hypertention	?

420.1
942

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. May 2-1949

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial
DATE THEREOF: May 4 49
NAME OF CEMETERY OR CREMATORY: St Luke's Cem
LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: May 3, 1949
REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc " "
ADDRESS

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limits

M

04330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 47 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 312 Fayette St.,	STREET ADDRESS (If rural, give location) 312 Fayette St.,

3. NAME OF DECEASED (Type or Print): (First) NETTIE (Middle) DURBIN (Last) HERSHISER

4. DATE OF DEATH: (Month) May (Day) 8, (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	Widowed	May 17, 1870	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Bedford, Penna.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mathew P. Spidel	Amanda Dickerhoof

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	VAnHorn T. Hershiser Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	18 mos
	(c)	

422.1
186a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fractured right hip; Diabetes — 10 weeks; 2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) Fractured hip — PLACE (Home, [redacted] OF INJURY) (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) Mar 5, 1949 4 P. m. — INJURY OCCURRED While at Work ☐ Not While At work ☒ — HOW DID INJURY OCCUR? Slipped on bedroom floor

22. I hereby certify that I attended the deceased from Mar 5, 1949, to May 9, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 6:00 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. W. Trevaskis, Sr — ADDRESS Cumberland — DATE SIGNED 5/9/49 Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/11/49	Bedford Cemetery	Bedford, Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
May 11, 1949	Winter R. Frantz, M.D.	Charles L. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAY 17 1949
BUREAU V. S.

04331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Eckhart Allg. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart, Md.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Leroy (Last) Himmelwright

4. DATE OF DEATH: (Month) May (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 16, 1897

9. AGE last birthday: 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Nathaniel Himmelwright

14. MOTHER'S MAIDEN NAME: Annie Kimberly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-07-0840

17. INFORMANT: Mrs. Leroy Himmelwright

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Liver C — Interval between Onset and Death:

156 **Antecedent cause(s)**

46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Metastasis Lungs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 May, 1949, to 19 May, 1949, that I last saw the deceased alive on 19 May, 1949, and that death occurred at 4:50 P.M. EST, from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, MD — ADDRESS: Frostburg, Md — DATE SIGNED: 5/21/49.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 5/22/49. — NAME OF CEMETERY OR CREMATORY: Porters Cemetery — LOCATION (City, town, or county) (State): Eckhart Md.

DATE REC'D BY LOCAL REG.: 5-21-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe — **24. FUNERAL DIRECTOR**: Jacob Hafer — ADDRESS: Frostburg Md

RECEIVED
MAY 23 1949
BUREAU OF S.

Within corporate limits

DR. HODGES

04332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~FAIRLAWAN, NEW JERSEY~~ LENGTH OF STAY (in this place) 5 hrs. 2 Min
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New Jersey COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FAIRLAWAN, NEW JERSEY
STREET ADDRESS (If rural, give location) MEMORIAL AVE., CUMBERLAND, MD.

3. NAME OF DECEASED (Type or Print) (First) ~~BABY GIRL~~ MARY (Middle) WILLIAMS (Last) HOLLAND

4. DATE OF DEATH (Month) MAY (Day) 23 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH MAY 23, 1949

9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours 6 Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM HOLLAND, JR.

14. MOTHER'S MAIDEN NAME ALICE WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH 4 hrs.

Immediate cause (a) Erythroblastosis fetalis

770.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) RH neg mother - RH + father

161c

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION (Exsanguination transfusion)

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/23, 1949, to 5/23, 1949, that I last saw the deceased alive on 5/23, 1949, and that death occurred at 6 00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W Royce Hodges, M.D. ADDRESS Cumberland, Md. DATE SIGNED 5/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 26, 1949

NAME OF CEMETERY OR CREMATORY HillCrest Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. May 25, 1949

REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04333

CERTIFICATE OF DEATH

Reg. Dist. No. 14

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Henry	Thornton	Holler		May	10	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	12/19/1859	89 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Pennsylvania	Usa

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Holler	Jane Huffard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Mrs. R.E. Stuby

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cancer Stomach	3 yrs.
151 Antecedent cause(s)		
460 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 19 47, to May 10, 19 49, that I last saw the deceased alive on May 10, 19 49, and that death occurred at 9A m., from the causes and on the date stated above.

SIGNATURE John A Topper MD (Degree or title) ADDRESS Hyndman Pa DATE SIGNED 5/12/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5/13/49	Lybarger	Madley	Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 13 1949	J. Lloyd Wolfe	Harvey H. Zeigler	Hyndman, Pa.

VS. A15

RECEIVED
JUL 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04334

Evidence for change of age is on!

FILM No. G 120 JUN - 3 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg LENGTH OF STAY (in this place) 30 yrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS 76 W. College Ave	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg STREET ADDRESS (If rural, give location) 76 W. College Ave.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frank	Leslie	Hoskins		May	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Dec. 12-1892	56 ~~57~~ yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Frostburg, Md	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Hoskins	Fanny Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	World I	172-14-2577	Mrs Frank Hoskins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 week
331 Antecedent cause(s)		several
830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1947, 19..... to May 20, 19 49, that I last saw the deceased alive on May 17, 19 49, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm Lane	M D	Frostburg Md	5-21-49

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	5-23-1949	Allegany Cem.	Frostburg,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-24-49	Mrs Nancy V. Ross	Jacob Hafer	Frostburg, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 27 1949
BUREAU V. S.

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04335

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 110 Reynolds street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 110 Reynolds Street

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Gertrude (Last) Jenkins

4. DATE OF DEATH (Month) May (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: November 21 1903

9. AGE last birthday: 45 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Cafeteria

11. BIRTHPLACE (State or foreign country): Harpers Ferry, W Va

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Fount Jackson

14. MOTHER'S MAIDEN NAME: Lacy Goldsberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-16-3401

17. INFORMANT: Walter J. Jenkins Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
170 Immediate cause	(a) Carcinoma Left Breast with Metastases	1½ years
50 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1949, to May 24, 1949, that I last saw the deceased alive on May 24, 1949, and that death occurred at 12:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. M. Schneider MD ADDRESS 41 Greene St, Cumberland, Md DATE SIGNED May 25, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 27, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 27, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer. ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

649 9 Mch.
R.R. Clark

RECEIVED
JUN 1 1949
BUREAU

04336

Evidence for change of birth date shown on:

FILM No. G 120 MAY 26 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 123 Pine St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 123 Pine St.

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) E. (Last) Johns

4. DATE OF DEATH (Month) 5 (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Oct. 11 1867
9. AGE last birthday 81 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Brode
14. MOTHER'S MAIDEN NAME Katherine Terlack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Harry Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

331 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertension, senility

83a (c) arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15, 1949, to 5.21, 1949, that I last saw the deceased alive on 5.21, 1949, and that death occurred at 4 A.m., from the causes and on the date stated above.

SIGNATURE H. C. Diehl, M.D. (Degree or title) ADDRESS Frostburg, Md. DATE SIGNED 5.21.49.

23. BURIAL, CREMATION REMOVAL (Specify) DATE 5-23-1949 NAME OF CEMETERY OR CREMATORY Allegany Cem LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 5-21-49 REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 23 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE IS ON:

FILM No. G 120, JUN - 3 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04337

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mitner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 13 Stafford

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Milton (Last) Kim

4. DATE OF DEATH: (Month) 5 (Day) 24 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 24-1891

9. AGE last birthday: 57 ~~58~~ yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist & Manager

10b. KIND OF BUSINESS OR INDUSTRY: Drug Store

11. BIRTHPLACE (State or foreign country): Pittsburgh Pa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James W. Kim

14. MOTHER'S MAIDEN NAME: Mamie Dietrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): World I

16. SOCIAL SECURITY No.: 194-01-0575

17. INFORMANT: Mrs. James M. Kim

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Bronchiogenic Carcinoma right lung — Interval between onset and death: 2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): 162 472

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/18/47

19b. MAJOR FINDINGS OF OPERATION: Bronchiogenic Carcinoma right lung

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 19 47, to May 24, 1949, that I last saw the deceased alive on May 24, 1949, and that death occurred at 5 40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Hilda Jane Walters M.D. — ADDRESS: 48 Broadway Frostburg Md. — DATE SIGNED: 5/25/49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE: 5-27-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 5-27-49 — REGISTRAR'S SIGNATURE: Mrs. Laney N. Roe

24. FUNERAL DIRECTOR — ADDRESS: Jacob Hafer Frostburg, Md.

VS. A15

RECEIVED
MAY 31 1949
BUREAU V. D.

Within corporate limits

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04338

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rt. #5, Cumberland Rural
STREET ADDRESS (If rural, give location) Rt #5 Cresap Park

3. NAME OF DECEASED (Type or Print): [redacted] (Leota) Leroda Bell (Middle) Kinser (Last)

4. DATE OF DEATH: (Month) May (Day) 18 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 23 1899

9. AGE last birthday: 49 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Allegany

13. FATHER'S NAME: Thomas Burley

14. MOTHER'S MAIDEN NAME: Jennie Bittner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-6487

17. INFORMANT: Edgar E. Kinser (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lymphosarcomatosis retroperitoneal & intestinal c perforation of jejunum — ? 2 mo.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

200.1
46.2

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION: as above | 20. AUTOPSY? Yes ☐ No ☐

21. ~~ACCIDENT~~ ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on May 18, 1949, and that death occurred at 9 35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

A. Mirkin M.D. 115 S. Centre St 5/19/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: May 21 '49 | NAME OF CEMETERY OR CREMATORY: Fillerest Cem | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: May 20, 1949 | REGISTRAR'S SIGNATURE: Winter R. Kantz M.D. | 24. FUNERAL DIRECTOR: Lomis Stem Inc | ADDRESS: Cumberland

VS. A15

RECEIVED
MAY 21 1949
BUREAU V. S.

04339

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton — LENGTH OF STAY (in this place) 75 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Branson (Last) Kyle	4. DATE OF DEATH (Month) May (Day) 7 (Year) 1949
5. SEX Male — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married — 8. DATE OF BIRTH May 21, 1874	9. AGE last birthday 74 yrs. — If under 1 year Months. Days — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if retired) Coal Miner — 10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frederick Kyle	14. MOTHER'S MAIDEN NAME Harriet Barnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If year, give war or dates of service) None — 16. SOCIAL SECURITY NO.	17. INFORMANT Margaret Lauder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chr - Myocarditis — 3

422.2 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to tha above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the diseasa or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/15, 1949, to 5/7, 1949, that I last saw the deceased alive on 5/7, 1949 and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE R W Reeves MD (Degree or title) ADDRESS Westernport Md DATE SIGNED 5/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 10, 1949	NAME OF CEMETERY OR CREMATORY Laurel Hill	LOCATION (City, town, or county) ~~Xxxxxxx~~ Moscow (State) Md.
DATE REC'D BY LOCAL REG. May 10/49	REGISTRAR'S SIGNATURE [illegible] MD	24. FUNERAL DIRECTOR Ellsworth S. Boal	ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 18 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04340

Reg. Dist. No. 4

The correct answer to each question is required. If unknown or not applicable, write "unknown" or "N.A."

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS La Vale

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) LaVale – West St.

3. NAME OF DECEASED (Type or Print): (First) Lorenzo (Middle) Dow (Last) Lambert

4. DATE OF DEATH: (Month) May (Day) 4 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Dec 16, 1863

9. AGE last birthday: 85 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant & Farmer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): W. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H Lambert

14. MOTHER'S MAIDEN NAME: America Yokum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter) Mrs. Murray

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis	several years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) also had arteriosclerosis	
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1946, to 5-4, 1949, that I last saw the deceased alive on 5-4, 1949, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE: H.V. Deming M.D. — (Degree or title) — ADDRESS: H.V. Deming Cumberland Md. — DATE SIGNED: May 5-1949

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial & Removal
DATE THEREOF: May 7th
NAME OF CEMETERY OR CREMATORY: Bonner Cem.
LOCATION (City, town, or county): Dry Fork (State): W. Va

DATE REC'D BY LOCAL REG.: May 6, 1949
REGISTRAR'S SIGNATURE: Wirt R. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc
ADDRESS: Cumberland

VS.A15

RECEIVED
MAY 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04341

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Gay St. rear Garment Factory.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 122 W. Old Town Road

3. NAME OF DECEASED (Type or Print): (First) Marylyn (Middle) Elaine (Last) Landis
4. DATE OF DEATH: (Month) May (Day) 23 (Year) 1949
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: June 29-1944
9. AGE last birthday: 4 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Carl E.Landis
14. MOTHER'S MAIDEN NAME: Rosella Lookenbaugh
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: -----
17. INFORMANT: C.E.Landis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia due to drowning. — at once

Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underlying cause last (b) walked or fell in pond.

(c)

929.8
183

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing tn the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: place of death | (CITY OR TOWN): Cumberland | (COUNTY): Allegany | (STATE): Md.
TIME OF INJURY: (Month) (Day) (Year) (Hour) May 23/49-2.30 P.M. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Walked or fell in pond.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. May 23-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: May 25, 1949 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 25, 1949 | REGISTRAR'S SIGNATURE: White R. Krantz. M.D. | 24. FUNERAL DIRECTOR: James T. Scargell | ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 1 1949
BUREAU T. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04342

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 421 Laing Ave

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Treller (Last) Lane

4. DATE OF DEATH (Month) May (Day) 27 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct. 28 1886

9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor

10b. KIND OF BUSINESS OR INDUSTRY Painting

11. BIRTHPLACE (State or foreign country) McFall, Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George R. Lane

14. MOTHER'S MAIDEN NAME Elizabeth Eichelberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1st. World War

16. SOCIAL SECURITY No. 705-12-4666

17. INFORMANT Leona Powell Lane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Hepatic Insufficiency	24 hours
199.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Carcinoma (metastatic) to liver	?
47d	(c)	Carcinoma (metastatic) to liver	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma, primary site undetermined

19a. DATE OF OPERATION no

19b. MAJOR FINDINGS OF OPERATION no

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) no (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) no m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from 6/18, 1947, to May 27, 1949, that I last saw the deceased alive on May 26, 1949, and that death occurred at 4 45 A.m., from the causes and on the date stated above.

SIGNATURE Saville A. Weisman (Degree or title) MD ADDRESS 122 Bedford St Cumberland, Md DATE SIGNED 5/27/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF June 1 1949

NAME OF CEMETERY OR CREMATORY Arlington National Cemetery

LOCATION (City, town, or county) Arlington, (State) Virginia

DATE REC'D BY LOCAL REG. May 29, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

RECEIVED
JUN 6 1949
BUREAU V. S.

DR. RICHARD WILLIAMS

04343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY: ALLEGANY — STATE: MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MARYLAND LENGTH OF STAY (In this place): 2 days HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland — COUNTY: Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland STREET ADDRESS (If rural, give location): 324 Bedford St.

3. NAME OF DECEASED (Type or Print): ROSS H. LEASURE	4. DATE OF DEATH: MAY 22 1949	5. SEX: MALE	6. COLOR OR RACE: WHITE - AMER.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: DEC. 27, 1888	9. AGE last birthday: 60 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman	10b. KIND OF BUSINESS OR INDUSTRY: SALESMAN	11. BIRTHPLACE (State or foreign country): PENN.	12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: LAFAYETTE LEASURE		14. MOTHER'S MAIDEN NAME: AGNES HAMILTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-05-8500	17. INFORMANT: Mrs. Ruth Leasure	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) Cumberland	(COUNTY) Alley	(STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/15/49, 19..., to 5/22/49, 19..., that I last saw the deceased alive on 5/22/49, 19..., and that death occurred at 7 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. H. Williams	M.D.	Cumberland Md	5/22/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 25, 1949	Fairview Christian Cemetery	Artemas, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 24, 1949	Walter L. Fantz, M.D.	William H. Kight	Cumberland, Md.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

04344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 39 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 167 Center St

3. NAME OF DECEASED (Type or Print) (First) Samuel (Middle) Jacob (Last) Martin

4. DATE OF DEATH (Month) 5 (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Feb 1-1890
9. AGE last birthday 59 yrs. If under 1 year Months 3 Days 7 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubber Worker
10b. KIND OF BUSINESS OR INDUSTRY Kelley Fin Co
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.G

13. FATHER'S NAME Henry Martin
14. MOTHER'S MAIDEN NAME Mary Wondorff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-6463
17. INFORMANT Mrs Samuel J. Martin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	6 hours
420.1 Antecedent cause(s)			
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Heart failure	several years
	(c)	Hypertension	several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-8, 1949, to 5-8, 1949, that I last saw the deceased alive on 5-8, 1949, and that death occurred at 4 30 a.m., from the causes and on the date stated above.

SIGNATURE Adolph Wolfermann (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 5-9-49.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 5-10-1949
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 5-9-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. ADDRESS

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 12 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04345

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 630 Shriver Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 630 Shriver Ave.,

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): David Isenberg Mateer
4. DATE OF DEATH (Month) (Day) (Year): May 23 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Aug. 26, 1880
9. AGE last birthday: 68 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Huntington, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Mateer
14. MOTHER'S MAIDEN NAME: Ella Neumer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: 217-10-6800
17. INFORMANT: Mrs. Anna Screen Mateer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Embolism	4 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemmorrhoidectomy	
	(c)	

461
836

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) H (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 3, 1945, to May 23 1949, that I last saw the deceased alive on May 23, 1949, and that death occurred at 9:05 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
L B Markers Jr 49 Greene St Cumberland, Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: May 25, 1949
NAME OF CEMETERY OR CREMATORY: Rose Hill
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 25, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

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JUN 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04346

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 75 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS 318 Hammond St.	STREET ADDRESS (If rural, give location) 318 Hammond St.

3. NAME OF DECEASED (Type or Print)	(First) Rebecca	(Middle) Jane	(Last) Mayhew	4. DATE OF DEATH	(Month) May	(Day) 5	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 17, 1865	9. AGE last birthday 83 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Henry Gentry	14. MOTHER'S MAIDEN NAME Amanada Carver						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. ------	17. INFORMANT Margaret Footen					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho pneumonia (terminal)	1 day
90210 Antecedent cause(s)	(b) Chronic Myocarditis	3 mo
1860 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Fracture left hip — — — —	3 mo.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arthritis — —	10 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	~~(CITY OR TOWN)~~ Westernport (COUNTY) Md (STATE) Allegany Co
TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 11, 1949 7 P m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR? Fell from Stool

22. I hereby certify that I attended the deceased from Jan 1, 1948 to May 4, 1949, that I last saw the deceased alive on May 4, 1949, and that death occurred at 1:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J Norman Reeves MD Westernport, Md 5/6/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 8, 1949	NAME OF CEMETERY OR CREMATORY Philos Cem.	LOCATION (City, town, or county) Westernport (State) Md.
DATE REC'D BY LOCAL REG. May 7/49	REGISTRAR'S SIGNATURE [illegible] MD	24. FUNERAL DIRECTOR Ellsworth S. Boal	ADDRESS Westernport Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAY 7 1949
BUREAU V. S.

P.E. Berry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

pp Reg. Dist. No. 04367

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke, Md.; MARYLAND; LENGTH OF STAY (In this place) 15 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS 215 Cromwell, Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 118 Jeffry, Street ✓

3. NAME OF DECEASED (Type or Print): (First) Raphael (Middle) (Last) Mazzone

4. DATE OF DEATH: (Month) May (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 23, 1913

9. AGE last birthday: 36 yrs. If under 1 year: Months 2 Days 8 Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder

10b. KIND OF BUSINESS OR INDUSTRY: Contract Welder

11. BIRTHPLACE (State or foreign country): Piedmont, W.Va.-Mineral

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leo Mazzone

14. MOTHER'S MAIDEN NAME: Marie Garafoli

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-0575

17. INFORMANT: Marie Helena Mazzone

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151 Immediate cause (a) Carcinoma of Stomach — Interval Between Onset and Death: 6 mo

Antecedent cause(s)

46 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) Duodenal Ulcer — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: April 29 49

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 18, 1949, to May 31, 1949, that I last saw the deceased alive on May 31, 1949, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

P.E. Berry M.D. Piedmont W.Va 6/2/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: June 3 1949 — NAME OF CEMETERY OR CREMATORY: St. Peters — LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG. June 3/49 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR: Ellsworth S. Boal — ADDRESS: 111 Church Westernport, Md.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04348

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MIDLAND Cumberland; LENGTH OF STAY (In this place): 10 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MIDLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): NONE

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	AGNES	Strahan	McALPINE		MAY	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOW	SEPT 8, ~~1878~~ 1877	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None ~~housewife~~		MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN BROWN	MARY ~~STRAUBEN~~ Strahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	None	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hepato-renal failure	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of gall-bladder c metastasis to liver; cholelithiasis & choledocholithiasis	6-12 mo 10 mo ?
	(c) Biliary cirrhosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Mild diabetes mellitus	yrs.

155
46f

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	as under (b) & (c) above	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
NO				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov -, 1947, to May 6, 1949, that I last saw the deceased alive on May 5, 1949, and that death occurred at 5 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. Mirkin	MD	115 S. Centre St.	5/6/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 9, 1949	Old Coney Cemetery	Lonaconing, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 9, 1949	Winter K. Dantz, M.D.	M. Eichhorn,	"

VS. A15

RECEIVED
MAY 17 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04349

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 723 Wallace St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 723 Wallace St.

3. NAME OF DECEASED (Type or Print): (First) Abram (Middle) Ladue (Last) McCullough

4. DATE OF DEATH: (Month) May (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married

8. DATE OF BIRTH: Jan. 11 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe fitter helper

10b. KIND OF BUSINESS OR INDUSTRY: Railway

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John McCullough

14. MOTHER'S MAIDEN NAME: Annie McCullough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Anna Hicks McCullough (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arteriosclerosis
(c)

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Cumberland (COUNTY) Alleg. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/24/49, 19..., to 5/5/49, 19..., that I last saw the deceased alive on 5/1/49, 19..., and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. Williams M.D. ADDRESS Cumberland Md. DATE SIGNED 5/6/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 7 49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REGISTRAR: May 6, 1949 — REGISTRAR'S SIGNATURE: Winter K. Lantz M.D.

24. FUNERAL DIRECTOR: Toms Stein Inc. — ADDRESS: Cumberland

RECEIVED
MAY 10 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04350

Reg. Dist. No. 4

M

Use correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): --
HOSPITAL OR INSTITUTION OR STREET ADDRESS: W.Md.R.Ry near River Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: W.Va — COUNTY: Summers
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hinton
STREET ADDRESS (If rural, give location): 303-13th Ave.

3. NAME OF DECEASED (Type or Print): (First) Earl (Middle) (Last) McKinster

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: April 5-1896

9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Stenson Ky.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Amos McKinster

14. MOTHER'S MAIDEN NAME: Mary Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 234-24-3215

17. INFORMANT: Mrs.L.F.Goins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exsanguination, also had crushed skull & — at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

802.3 169

(b) Chest, fractured limbs, right leg servered

(c) at knee. Trespasser. hit by a W.Md. freight train.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: W.Md.R.Ry.

(CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 5-28-49-8.30 P.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?: Trespasser, hit by a freight engine.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. — H. V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: May 29-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 6-3-1949

NAME OF CEMETERY OR CREMATORY: Allegany Co. Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: June 2, 1949

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George

ADDRESS: Cumberland, Md.

VS. A15A

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04351

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE Maryland	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 312 Mountain View Drive	STREET ADDRESS (If rural, give location) 312 Mountain View Drive

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Georgia	Irene	Snellinger		May	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	March 30 1869	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Cumberland Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George R. Kephart	Maria Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Warren Snellinger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Arteriosclerosis	Several years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Chronic nephritis	" "
(c)		

592 61

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 3-11-47, 1947, to May 13, 1949 that I last saw the deceased alive on May 2, 1949, and that death occurred at 8.45 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charlotte B. Andres	M.D.	Cumberland Md.	5-13-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 15 1949	Rose Hill Mausoleum	Cumberland	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 15, 1949	Walter R. Frantz M.D.	Louis Stein, Inc.	Cumberland, Maryland.

VS. A15

RECEIVED
MAY 25 1949
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

DR. A. JONES

04352

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYALND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 73 LAING AVE.

3. NAME OF DECEASED (Type or Print): (First) LILLIAN (Middle) (Last) MILLER

4. DATE OF DEATH: (Month) May (Day) 23 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: Oct 2, 1892

9. AGE last birthday: 54 yrs. — If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York, N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PHILLIP SIMOM

14. MOTHER'S MAIDEN NAME: SADIE LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Ester Uplinger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremic Poisoning - Chronic Nephritis	3 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular renal disease	5 yrs
	(c) Diabetes Mellitus	6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 12, 1949, to May 23, 1949, that I last saw the deceased alive on May 21, 1949, and that death occurred at 5 00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. May 23, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: May 24, 1949

NAME OF CEMETERY OR CREMATORY: Agudith Achin

LOCATION (City, town, or county) (State): Altoona, Pa.

DATE REC'D BY LOCAL REG.: May 23, 1949

REGISTRAR'S SIGNATURE: Winter K. Prantz

24. FUNERAL DIRECTOR: James F. Scarpelli

ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04353

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 25 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Pa — COUNTY: Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Centerville (rural)
STREET ADDRESS (If rural, give location): Bedford Pa. R.F.R.#3 ✓

3. NAME OF DECEASED (Type or Print): (First) Norman Herbert (Middle) (Last) Miller

4. DATE OF DEATH: (Month) May (Day) 24 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Dec.15-1934

9. AGE last birthday: 14 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bedford Co. Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: C.Raymond Miller

14. MOTHER'S MAIDEN NAME: Mary Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: C.R.Miller

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

919.8 **Immediate cause** (a) due to a penetrating gunshot wound, left chest.

184 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mediastinal shift (collapsed right lung) & Exsanguination due to traumatic avulsion of left forearm, due to a 12 gauge shotgun wound. — 2.1/2 hours

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: woods | (CITY OR TOWN): about 6 miles from Centerville | (COUNTY): Bedford | (STATE): Pa.

TIME (Month) (Day) (Year) (Hour) OF INJURY: May 24 ?49 3.30 Pm. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR?: Crawling through fence, gun accidently discharged.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. | (Degree or title) | ADDRESS: Cumberland Md. | DATE SIGNED: May 25-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 5/28/49 | NAME OF CEMETERY OR CREMATORY: Friendship Cemetery | LOCATION (City, town, or county) (State): Centerville, Md.

DATE REC'D BY LOCAL REG.: May 27, 1949 | REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hoffer | ADDRESS: Cumberland, Md.

RECEIVED
JUN 1 1949
BUREAU V.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04354

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 70 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 223 West Oldtown Rd

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Perry	Vernon	Miller	May	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	April 15 1875	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miller (Retired)	B & O Ry	Bedford Co. Pa	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Miller	Martha Ellen Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.			Myrtle Morris Miller (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio-sclerotic heart disease with cardiac failure

155 469

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Macrocytic anemia, severe, cause undetermined. May have been primary or secondary to carcinoma of liver.

XOO Did not live long enough to make complete investigation.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from May 14, 1949, to May 19, 1949, that I last saw the deceased alive on May 19, 1949, and that death occurred at 7 30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Winfred Van Orma	M.D.	531 Louisiana Ave., Cumb., Md.	5/20/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 22 '49	Hyndman Cem	Hyndman, Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 20, 1949	Walter R. Hartz, M.D.	Louis Stein Inc.	Cumberland

VS: A15

RECEIVED
MAY 25 1949
BUREAU Y. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

014355

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Cumberland
LENGTH OF STAY (In this place): 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Bowman's Addition

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 625 Princeton St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Merten	Isaac	Morgan	May	17	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	April 4-1889	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Allegany Feed Co.
11. BIRTHPLACE (State or foreign country): Flintstone Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel C. Morgan
14. MOTHER'S MAIDEN NAME: Mary Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-05-7477
17. INFORMANT: Wm.E.Morgan (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis	about 3 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V.Deming M.D.		Cumberland Md.	May 17-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-19-49	Prosperity Methodist	Beans Cove Road Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 19, 1949	Winter R. Frantz, M.D.	John J.Hafer	Cumberland Md.

VS. A15A

RECEIVED
MAY 25 1949
BUREAU V. M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

014356

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 523 Avirett Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 523 Avirett Ave.

3. NAME OF DECEASED (Type or Print): (First) Katherine (Middle) M. (Last) Mosser

4. DATE OF DEATH: (Month) May (Day) 19 (Year) 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 30, 1864

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Manns Choice, Pa.

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: David Black

14. MOTHER'S MAIDEN NAME: Anna McNeal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Peter G. Cowden

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hepatic coma — 4 days

155 / 46f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) obstruction jaundice — 4 weeks

(c) cancer of the gallbladder — 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-1-, 1949, to 5-19-, 1949, that I last saw the deceased alive on 5-19-, 1949, and that death occurred at 6 40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L Brings MD — ADDRESS 59 Greene St. — DATE SIGNED 5-20-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: May 22, 1949 — NAME OF CEMETERY OR CREMATORY: Manns Choice, Pa. — LOCATION (City, town, or county) (State): Manns Choice, Pa.

DATE REC'D BY LOCAL REG.: May 21, 1949 — REGISTRAR'S SIGNATURE: Walter R. Beatty, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
MAY 25 1949
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04357

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural
LENGTH OF STAY (in this place) 31 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Gap

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown
STREET ADDRESS (If rural, give location) Rt, 1.

3. NAME OF DECEASED (Type or Print) (First) Fannie (Middle) (Last) Mullenax

4. DATE OF DEATH (Month) May (Day) 14 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH November 17 1878

9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House

10b. KIND OF BUSINESS OR INDUSTRY House

11. BIRTHPLACE (State or foreign country) Pendleton Co, West Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Jacob S. Teter

14. MOTHER'S MAIDEN NAME Sadie Lantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Sherman Athey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Bladder — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

181 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

52 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19 to 5-15, 1949, that I last saw the deceased alive on 5-1-, 1949 and that death occurred at 1-35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] Cumberland Md 5-15-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 17 1949

NAME OF CEMETERY OR CREMATORY Oldtown Cemetery

LOCATION (City, town, or county) Oldtown (State) Maryland

DATE REC'D BY LOCAL REG. May 16, 1949

REGISTRAR'S SIGNATURE Winter R. Lantz M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

RECEIVED
MAY 25 1949
BUREAU V. S.

Within corporate limits

M

04358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 30 Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 255 Elder St.	STREET ADDRESS (If rural, give location) 255 Elder St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) C.H. Alfred S. Northcraft	4. DATE OF DEATH (Month) (Day) (Year) May 11, 1949 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
M	W	Divorced	Sept. 15, 1869	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Handyman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chaneyville Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Hezekiah Northcraft		14. MOTHER'S MAIDEN NAME Caroline Haney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 212-12-8549	17. INFORMANT Mrs Bessie P. Beck	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1949 to May 11, 1949, that I last saw the deceased alive on May 10, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Cleary E. Durrett	M.D.	Cumberland, Md.	5/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 13, 1949	Mt. Zion Cem.	Chaneyville, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 12, 1949	Winter R. Frantz, M.D.	James F. Scarpelli	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1949
BUREAU V. S.

04359

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 46 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 35 Mt. Pleasant

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 35 Mt. Pleasant

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) (Last) Panse

4. DATE OF DEATH (Month) 5 (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov. 26, 1873
9. AGE last birthday 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Confectionery
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Pasquale Panse
14. MOTHER'S MAIDEN NAME Mary Zumpano

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr Bert Panse

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart failure	3 months
523.0 Antecedent cause(s)		
114a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) silicosis	many years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-1, 1949, to 5-9, 1949, that I last saw the deceased alive on 5-8, 1949, and that death occurred at 6 30 a.m., from the causes and on the date stated above.

SIGNATURE L. Adolph Volferman (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 5-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE May 12-1949
NAME OF CEMETERY OR CREMATORY St. Michaels Cem.
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 5-9-49
REGISTRAR'S SIGNATURE Mr. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04360

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
LENGTH OF STAY (In this place) 27 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Savage

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) Robert (Last) Petenbrink

4. DATE OF DEATH (Month) May (Day) 12 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-1-1889
9. AGE last birthday 62 yrs. If under 1 Months. 1 year Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Case Taker
10b. KIND OF BUSINESS OR INDUSTRY County Home
11. BIRTHPLACE (State or foreign country) Williamsburg, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Petenbrink
14. MOTHER'S MAIDEN NAME Anna Marie Everline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 213-01-4668
17. INFORMANT Mrs Arnold Ballard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1/2 hour

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Had a Coronary attack 3 weeks ago and May 7th Coronary attack lasting about an hour (c) Had no apparent heart trouble

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949 to May 7, 1949 (May 12), that I last saw the deceased alive on May 1, 1949, and that death occurred at 1230a m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray (Degree or title) Md ADDRESS 41 Green St Cumberland Md DATE SIGNED May 13 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 5-14-1949
NAME OF CEMETERY OR CREMATORY Portis's Cemetery
LOCATION (City, town, or county) Eckhart Md (State)

DATE REC'D BY LOCAL REG. 5-14-49
REGISTRAR'S SIGNATURE Vernon McDermott
24. FUNERAL DIRECTOR Jacob Nafer Frostburg, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04361

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (In this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Stoney Run Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): Stoney Run Road

3. NAME OF DECEASED (Type or Print): (First) Veronika (Middle) (Last) Plosz

4. DATE OF DEATH: (Month) May (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 27-1888

9. AGE last birthday: 60 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungaria

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Foldi Peter

14. MOTHER'S MAIDEN NAME: Bino Barbara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Steve Plosz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocarditis — Interval between onset and death: ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming, M.D. H. V. Deming M.D. Cumberland Md. May 23- 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 5/25/49 | NAME OF CEMETERY OR CREMATORY: St Peter | LOCATION (City, town, or county) (State): Westernport Md

DATE REC'D BY LOCAL REG.: 5/25/49 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: E.L. Boal - Westernport, Md

RECEIVED
MAY 26 1949
BUREAU V. S.

04362

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 117 Walnut St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 117 Walnut St.

3. NAME OF DECEASED (Type or Print): (First) EMERY (Middle) GEORGE (Last) PLUMMER

4. DATE OF DEATH: (Month) May (Day) 14, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 4/14/1888

9. AGE last birthday: 61 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis A. Plummer

14. MOTHER'S MAIDEN NAME: Amanda Michaels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Eleanor Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 1 Day

260 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

61

(b) Hypertension — several years

(c) Diabetes — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1943, 19..., to May 14, 1949, that I last saw the deceased alive on May 13, 1949, and that death occurred at 6 30 P m., from the causes and on the date stated above.

SIGNATURE: W O McLane MD (Degree or title) — ADDRESS: Frostburg — DATE SIGNED: May 16 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 5/17/49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 5-17-49 — REGISTRAR'S SIGNATURE: Mrs. Harvey N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
MAY 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
MARYLAND
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) East Main Street.

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) (Last) Price

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Oct. 20th, 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months. If under 1 day: Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Price

14. MOTHER'S MAIDEN NAME: Ann Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John Stewart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio-Vascular-Renal disease with Uraemia — Interval between onset and death: 6 months

442 Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 25, 1949, to May 28, 1949, that I last saw the deceased alive on May 27, 1949, and that death occurred at 4:00 A m., from the causes and on the date stated above.

SIGNATURE W. E. Gatten (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED 5/28/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 5-29-49
NAME OF CEMETERY OR CREMATORY: Allegany
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 5-30-49
REGISTRAR'S SIGNATURE Mrs. Nancy K. Roe
24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Frostburg, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04364

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 27 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Palace Theatre

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 102 Bowery St

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Lavelle (Last) Richardson

4. DATE OF DEATH: (Month) May (Day) 11 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July-1-1906

9. AGE last birthday: 42 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oiler

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Vale Summit Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Milford Richardson

14. MOTHER'S MAIDEN NAME: Nellie Lavelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes War 2

16. SOCIAL SECURITY NO.: 214-07-6604

17. INFORMANT: brother) Bruce Richardson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Angina Pectoris	2 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Palace Theatre
(CITY OR TOWN): Frostburg (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H. V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: May 12-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 5-16-1949
NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery
LOCATION (City, town, or county): Frostburg (State): Md.

DATE REC'D BY LOCAL REG.: 5-13-49
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md.

RECEIVED
MAY 16 1949
BUREAU V. S.

Within corporate limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04365

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 78 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 230 Averett Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 230 Averett Avenue

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Wesley (Last) Richardson

4. DATE OF DEATH: (Month) May (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: August 28 1870

9. AGE last birthday: 78 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Building Contractor

11. BIRTHPLACE (State or foreign country): Somerset Co., Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Richardson

14. MOTHER'S MAIDEN NAME: Jane Foy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Kirk C. Richardson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — years

4/20.1
94a

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1949, to May 3, 1949, that I last saw the deceased alive on May 3, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. M. Schindler M.D. | ADDRESS 41 Greenway | DATE SIGNED May 6, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF May 6, 1949 | NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum | LOCATION (City, town, or county) (State) Cumberland, Alleg. Md

DATE REC'D BY LOCAL REG. May 6, 1949 | REGISTRAR'S SIGNATURE Winter K. Frantz, M.D. | 24. FUNERAL DIRECTOR John J. Hofer | ADDRESS Cumberland, Md.

VS. A15

RECEIVED
MAY 10 1949
BUREAU V. S.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04366

FILM No. G 12C MAY 25 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (in this place): 2 Da; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Meneis Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Midland; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Joseph (Last) Riley

4. DATE OF DEATH: (Month) May (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Priest

8. DATE OF BIRTH: Oct. 4-1904

9. AGE last birthday: 44 45 yrs. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roman Catholic

10b. KIND OF BUSINESS OR INDUSTRY: Priest

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Riley

14. MOTHER'S MAIDEN NAME: Mary Fahey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Sister Aleda (Balto)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 1 Day

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b)

942a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): No (CITY OR TOWN): No (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): No m.

INJURY OCCURRED: While at Work ☐ Not ~~While~~ At work ☒ No

HOW DID INJURY OCCUR?: No

22. I hereby certify that I attended the deceased from May 9, 19..., to May 9, 1949, that I last saw the deceased alive on May 9, 1949, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

SIGNATURE: W O McLane (Degree or title): MD ADDRESS: Frostburg Md DATE SIGNED: May 10 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | **DATE**: 5-13-49 | **NAME OF CEMETERY OR CREMATORY**: Holy Cross Cem | **LOCATION (City, town, or county) (State)**: Baltimore, Md.

DATE REC'D BY LOCAL REG.: 5-11-49 | **REGISTRAR'S SIGNATURE**: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR | **ADDRESS**: Joseph R. Durst Frostburg Md.

RECEIVED
MAY 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

014367

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport | LENGTH OF STAY (in this place) 83yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 Philos Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport, Md.
STREET ADDRESS (If rural, give location) 103 Philos Ave.

3. NAME OF DECEASED (Type or Print): (First) Edwin James (Middle) (Last) Roberts

4. DATE OF DEATH: (Month) May (Day) 27 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 20. 1865

9. AGE last birthday: 83 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal operator

10b. KIND OF BUSINESS OR INDUSTRY: Coal mine

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Simon Roberts

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT: Rhuel Roberts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchio-pneumonia (Terminal)	12 hrs.
420.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	6 yrs
	(c) Chronic Myocarditis	6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral embolism - hemiplegia (R) 6 yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1944, to May 27, 1949, that I last saw the deceased alive on May 26, 1949, and that death occurred at 1.00 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Norman Reuel M.D. | ADDRESS Westernport, Md | DATE SIGNED 5/27/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 5/29/49 | NAME OF CEMETERY OR CREMATORY Philos Cem. | LOCATION (City, town, or county) (State) Westernport Md.

DATE REC'D BY LOCAL REG. 5/29/49 | REGISTRAR'S SIGNATURE [illegible] MD

24. FUNERAL DIRECTOR ADDRESS: Ellsworth S. Boal, WESTERNPORT, MD.

RECEIVED
MAY 31 1949
BUREAU V. S.

Within corporate limits

mw

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04368

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) William (Last) RRuby

4. DATE OF DEATH (Month) May (Day) 17 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH Dec.14-1926

9. AGE last birthday 22 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer

10b. KIND OF BUSINESS OR INDUSTRY Saw Mill worker

11. BIRTHPLACE (State or foreign country) Bedford Co. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S/A

13. FATHER'S NAME Frank H. Ruby

14. MOTHER'S MAIDEN NAME Bessie R. Heavner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Severe laceration of brain tissue	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) and cerebral edema due to a fracture of	
	(c) the skull.	

821.5

170 d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ & CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway

(CITY OR TOWN) Beans Cove Rd. near Cumberland (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) May (Day) 15 (Year) 1949 (Hour) 12.30 P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Thrown from motorcycle

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED May 17 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 19, 1949

NAME OF CEMETERY OR CREMATORY Beans Cove Methodist

LOCATION (City, town, or county) Beans Cove Road (State) Pa.

DATE REC'D BY LOCAL REG. May 19, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

T

RECEIVED
MAY 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

043611

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (Rural) near, Flintstone
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.2 Flintstone Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) near, Flintstone Md.
STREET ADDRESS (If rural, give location): R.F.D 2, Flintstone Md.

3. NAME OF DECEASED (Type or Print): (First) Ira (Middle) Owen (Last) Shipley

4. DATE OF DEATH: (Month) May (Day) 4 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Dec. 23-1912

9. AGE last birthday: 36 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman, Spining, Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Artemas Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Owen Shipley

14. MOTHER'S MAIDEN NAME: Clara Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 217-10-4053

17. INFORMANT: (sister) Mrs. Ada Fletcher.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exsanguination, due to rupture of the lungs — at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

981
166

(b) aorta & heart, from a 12 guage shotgun,

(c) discharged by his brother.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: near farm home, near (CITY OR TOWN) Flintstone (COUNTY) Allegany (STATE) Md.

TIME OF INJURY: (Month) (Day) (Year) (Hour) May 4/49-7 P.m.

INJURY OCCURRED While at work [ ] Not while at work [X]

HOW DID INJURY OCCUR? Quarrel between brothe
One brother shot his brother.

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. May 5-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: May 7, 1949 — NAME OF CEMETERY OR CREMATORY: Glendale Brethren — LOCATION (City, town, or county) (State): Flintstone, Alleg. Md

DATE REC'D BY LOCAL REG.: May 7, 1949 — REGISTRAR'S SIGNATURE: Nina L. Bender.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hofer, Cumberland, Md.

RECEIVED
MAY 10 1949
BUREAU V. S.

Dr. L. Brings

04370

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown — LENGTH OF STAY (in this place) 29 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
HOSPITAL OR INSTITUTION OR STREET ADDRESS 45 Winchester Road.	STREET ADDRESS (If rural, give location) 45 Winchester Road

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Thompson	(Last) Sindy	4. DATE OF DEATH	(Month) May (Day) 24 (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1885	9. AGE last birthday 63 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman	10b. KIND OF BUSINESS OR INDUSTRY C.C. of A.	11. BIRTHPLACE (State or foreign country) Moorefield, W.Va.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John Thomas Sindy	14. MOTHER'S MAIDEN NAME Eliza Herbaugh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY No.	17. INFORMANT Mrs. John T. Sindy			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute coronary occlusion	1/2 hour
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic heart disease	1 year
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1, 1948, to May 24, 1949, that I last saw the deceased alive on May 22, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Brings	MD	59 Greene St. Cumberland	5-25-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 27, 1949	NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. May 27, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR John J Hafer	ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 3 1949
BUREAU V. S.

Within corporate limits

Broadrup

04371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 36 Mary St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Sisk

4. DATE OF DEATH: (Month) May (Day) 17 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/24/79

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Ross Wortman

14. MOTHER'S MAIDEN NAME: Esther Hester ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James A. Sisk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Mitral Regurgitation	Two years
450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	arteriosclerosis	Five years.
92.0	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1947, to May 17, 1949, that I last saw the deceased alive on May 17, 1949, and that death occurred at 8:05 P. m., from the causes and on the date stated above.

SIGNATURE: S S Broadrup Jr. — (Degree or title) M.D. — ADDRESS: Cumberland Maryland — DATE SIGNED: 5-19-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 5/20/49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: May 20, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer Cumberland Md.

RECEIVED
MAY 25 1949
BUREAU V. S.

Within corporate limits

DR. FAW

04372

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. VA COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) ESTON (Last) SMITH

4. DATE OF DEATH (Month) MAY (Day) 28 (Year) 1949

5. SEX male

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH AUG. 22, 1911

9. AGE last birthday 37 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Grant County W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN SMITH

14. MOTHER'S MAIDEN NAME MINNIE SHIRK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Father: John Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Portal Thrombosis - Portal Vein

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adeno-Carcinoma Transverse Colon c̄ obstruction and lymph node metastasis

(c)

153

46e

INTERVAL BETWEEN ONSET AND DEATH: 3 days May 25-49; 25 days May 3-49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION May 17 1949

19b. MAJOR FINDINGS OF OPERATION Obstructive adeno-carcinoma transverse colon c̄ metastasis

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 16, 1949, to May 28, 1949, that I last saw the deceased alive on May 28, 1949, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE Wylie M. Faw Jr. (Degree or title) M.D. ADDRESS Cumberland, Maryland. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF May 30, 1949

NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery

LOCATION (City, town, or county) Lahmansville, West Virginia (State)

DATE REC'D BY LOCAL REG. May 29, 1949

REGISTRAR'S SIGNATURE Winter R. Kantz, M.D.

24. FUNERAL DIRECTOR P. E. Thrush and Son, Petersburg, W. Va. ADDRESS

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

014373

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 118 Elder St.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) G. (Last) Smith

4. DATE OF DEATH: (Month) May (Day) 24 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 3. 1907

9. AGE last birthday: 41 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer, Rolling Mill

10b. KIND OF BUSINESS OR INDUSTRY: B&O. R.Ry

11. BIRTHPLACE (State or foreign country): Md. (Eckhart)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam C. Smith

14. MOTHER'S MAIDEN NAME: Mary Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-09-3444

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause
(a) (massive) Pulmonary embolism, due to fract- — about 19 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) ures of the 6,7,8,10 ribs right side of chest Hydropneumothorax, right lung, contusion and abrasions, right side of chest & pelvis
(c) Hit by a B&O, R.Ry train.

802.5
169

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Acute cardiac dilatation & congestion of the viscera

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: B&O. R.Ry
(CITY OR TOWN) near Cumberland (COUNTY) Allegany (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: 5.5/49-10.30P m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Sitting along tracks, hit by train.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: May 24-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May 28, 1949
NAME OF CEMETERY OR CREMATORY: Porter Cemetery
LOCATION (City, town, or county) (State): Eckhart Md.

DATE REC'D BY LOCAL REG.: May 27, 1949
REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md.

VS. A15A

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JUN 1 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04374

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 454 Walnut St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Margaret (Last) Stein
4. DATE OF DEATH (Month) May (Day) 16 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 18 1926
9. AGE last birthday 22 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Westernport Ind
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Sangiovanni
14. MOTHER'S MAIDEN NAME Calogiro Cannistratro
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 220-16-6390
17. INFORMANT Paul Stein Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Decompensation

642.3 Antecedent cause(s)

144a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Eclampsia

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pregnancy Term.

19a. DATE OF OPERATION 16 May 49.
19b. MAJOR FINDINGS OF OPERATION Post mortem Caesarian Section Delivery living Infant
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to 16 May, 1949, that I last saw the deceased alive on 15 May, 1949 and that death occurred at 11 20 p m., from the causes and on the date stated above.

SIGNATURE Fuller B Whitworth (Degree or title) ADDRESS 112 Bedford St. Cumberland DATE SIGNED May 16 '49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE May 20 49
NAME OF CEMETERY OR CREMATORY St Peter & Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Ind

DATE REC'D BY LOCAL REG. May 19, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

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MAY 25 1949
BUREAU U. S.

Within corporate limits

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04375

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 454 Walnut St.

3. NAME OF DECEASED (Type or Print) (First) Yvonne (Middle) Marie (Last) Stein

4. DATE OF DEATH (Month) May (Day) 18 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH May 16 '49
9. AGE last birthday — yrs. If under 1 year Months — Days 2 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Paul Stein Jr.
14. MOTHER'S MAIDEN NAME Mary M. Sangiovannia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Paul Stein Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Anoxemia (Irreversible)

762.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Maternal Anoxemia

161a (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 May, 1949, to 18 May, 1949, that I last saw the deceased alive on 18 May, 1949, and that death occurred at 4:20 A.m., from the causes and on the date stated above.

SIGNATURE Fuller B. Mutworth (Degree or title) ADDRESS Cumberland Md DATE SIGNED 19 May 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 20 49
NAME OF CEMETERY OR CREMATORY St. Peter + Pauls Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. May 19, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

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MAY 25 1949
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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04376

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 55 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1021 Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 1021 Virginia Ave

3. NAME OF DECEASED (Type or Print): (First) John (Middle) W. (Last) Stotler

4. DATE OF DEATH: (Month) May (Day) 7, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 25 1896

9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Craneman

10b. KIND OF BUSINESS OR INDUSTRY: B & O R R.

11. BIRTHPLACE (State or foreign country): Morgan County, West Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Stotler

14. MOTHER'S MAIDEN NAME: Virginia McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-12-3268

17. INFORMANT: Mrs. Daisy Stotler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval Between Onset and Death: 24 Hrs.

153 / 46a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma D colon with — 2 months

(c) generalized Metastasis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/5/49, to 5/7/49, that I last saw the deceased alive on 5/7/49, and that death occurred at 2:35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A. Dyer MD — ADDRESS 247 Virginia ave. — DATE SIGNED 5/7/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 10, 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 9, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz, MD — 24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md. — ADDRESS

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MAY 17 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11-2-27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 66 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 318 N. Waverly Terrace

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) William (Last) Troll

4. DATE OF DEATH: (Month) May (Day) 25 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept 22 188X

9. AGE last birthday: 66 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Gas Stand

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Troll

14. MOTHER'S MAIDEN NAME: Mary Gellner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: 214-07-1192

17. INFORMANT: Mrs Lela Riley Troll (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	2 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Status Asthmaticus	3 mos
	(c)	

422.2
938

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19 49, to May 25, 19 49, that I last saw the deceased alive on May 24, 1949, and that death occurred at 2:45 P. m., from the causes and on the date stated above.

SIGNATURE: Clay R. Lurrett (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: May 25, 1949.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: May 28 49

NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: May 27, 1949

REGISTRAR'S SIGNATURE: Wendell R. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Steiss, Inc ADDRESS: Cumberland

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits

04378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) [redacted] (Last) EDWARD Twigg
4. DATE OF DEATH (Month) May (Day) 10 (Year) 1949

5. SEX Male
6. COLOR OR RACE White [redacted]
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH May 10 1949
9. AGE last birthday — yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland, Cumberland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Andrew Cecil Twigg
14. MOTHER'S MAIDEN NAME Bessie Sirbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Andrew C. Twigg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Prematurity	6 months baby	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)		
	(c)		

776
159

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE B. M. Schindler M.D. (Degree or title) ADDRESS 41 Greenett DATE SIGNED May 11, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 11 1949
NAME OF CEMETERY OR CREMATORY Twigg Cemetery
LOCATION (City, town, or county) Rush-Allegany County (State) Maryland

DATE REC'D BY LOCAL REG. May 11, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1949
BUREAU V. S.
RECEIVED
MAY 17 1949
BUREAU V. S.

Within corporate limits

Evidence for addition in 19b is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04379

CERTIFICATE OF DEATH

Reg. Dist. No. 4

FILM No. G 121 JUL -8 1949

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 21 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1303 Lafayette Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1303 Lafayette Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Meldria	June	Twigg	May	30	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	Single	June 22, 1927	21 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Kenova Twigg	Gertrude E. Emerick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Kenova Twigg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Cardiac failure	7 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Rheumatic fever, Active (7/19/49 a.s.)	2 yr.
(c)		

401.3
594

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. malnutrition

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 5-26-, 1949, to 5-30-, 1949, that I last saw the deceased alive on 5-30-, 1949, and that death occurred at 6:25A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John A. Dyer	M.D.	247 Virginia Ave.	6-1-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 1, 1949	Oldtown Cemetery	Oldtown, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 1, 1949	Winter R. Frantz, M.D.	John J. Hofer, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04380

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 403 Avirett Ave.	STREET ADDRESS (If rural, give location) 403 Avirett Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Henry		Vernall	May	25,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	July 13, 1883	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired R.R. Co.	Baggageman	Tunstall, England	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Vernall	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	705-10-7893	Mrs. Emmaline Vernall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (422.2 93d)	(b) Chronic Myocarditis	3 yrs
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	Cumberland	Alleg.	Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—			— m.		—

22. I hereby certify that I attended the deceased from 12/1/47, 19..., to 5/25/49 19..., that I last saw the deceased alive on 5/25/49, 19..., and that death occurred at 8:02 a.m., from the causes and on the date stated above.

SIGNATURE C. H. Williams (Degree or title) M.D. ADDRESS Cumberland Md. DATE SIGNED 5/27/49

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-27-1949	HillCrest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 26, 1949	Walter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04381

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 62 yrs; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS 137 Humbird St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 137 Humbird St.,

3. NAME OF DECEASED (Type or Print): (First) Esther (Middle) Frances (Last) Weller

4. DATE OF DEATH: (Month) May (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 18, 1887

9. AGE last birthday: 62 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: — Wrightson

14. MOTHER'S MAIDEN NAME: — Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Howard B. Weller (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	18 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	?
331 83a	(c) Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY —

(CITY OR TOWN) Cumberland (COUNTY) Alleg. (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 5/23/49, 19....., to 5/24/49, 19....., that I last saw the deceased alive on 5/23/49, 19....., and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. M. Williams M.D. Cumberland Md 5/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: May 26, 1949

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland, Alleg. Md.

DATE REC'D BY LOCAL REG.: May 26, 1949

REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: John J. Hofer

ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04382

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 217 Dexter Place

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Florence		White	May	8	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	married	May 28-1890	~~59~~ 58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Hyndman Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Morris	Martha DeVore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	----	Albert R. White (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cardiac paralysis	3 days
884.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 179X (b) Acute bromide poisoning	
(c) nervousness due to alcoholism.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. edema of the brain. Chronic myocarditis & Coronary sclerosis.	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	al	Cumberland Md	May 16 - 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 11, 1949	Trinity Lutheran Cem	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 11, 1949	Walter L. Frantz, M.D.	William A. Keight	Cumberland, Md.

RECEIVED
MAY 18 1949
BUREAU V. S.

Within corporate limits

DR.W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

014383

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 34 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD, COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD
STREET ADDRESS (If rural, give location) 102 OAK ST.,

3. NAME OF DECEASED (Type or Print): (First) MARSHALL (Middle) (Last) WILLISON

4. DATE OF DEATH: (Month) MAY (Day) 16 (Year) 1949

5. SEX: male

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: DEC. 4 1884

9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): foreman B & O R.R.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME: GEORGE S WILLISON

14. MOTHER'S MAIDEN NAME: REBECCA HITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: 705-09-3704

17. INFORMANT: Wife sname address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

157 Immediate cause (a) Metastatic Carcinoma — ?

46g Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Primary Site Pancreas — 1

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.7, 1949 to 5.16, 1949, that I last saw the deceased alive on 5.16, 1949, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams (Degree or title) ADDRESS Cumberland DATE SIGNED 5.17.49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 19, 1949 — NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: May 18, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz M.D.

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli Cumberland, Md.

VS. A15

RECEIVED
MAY 25 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04384

Reg. Dist. No. 6

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport — LENGTH OF STAY (in this place): 19 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 114 Rail Road St.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 114 Rail Road St.	STREET ADDRESS (If rural, give location): Westernport, Md.

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) Edward (Last) Wills			4. DATE OF DEATH (Month) May (Day) 8 (Year) 1949	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb 24, 1882	9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman	10b. KIND OF BUSINESS OR INDUSTRY: Rail Road	11. BIRTHPLACE (State or foreign country): Mt. Savage Md.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: John P. Wills		14. MOTHER'S MAIDEN NAME: Martha Thorp		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): None	16. SOCIAL SECURITY NO.: —	17. INFORMANT: Mrs. Lottie Wills		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive heart failure — 2 months

443 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive cardiovascular disease — 5 yrs

93d (c) ✓

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 24, 1947, to May 8, 1949, that I last saw the deceased alive on May 8, 1949, and that death occurred at 3:20 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H Wolverton Jr	MD	Piedmont W. Va	May 10, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 11, 1949	Rose Hill Cem.	CUMBERLAND Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 11/49	[illegible] MD	Ellsworhth S. Boal	Westernport Md.

RECEIVED
MAY 18 1949
BUREAU T. S.

Evidence for addition of mother's and father's names is on:

FILM No. G 120 MAY 27 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04385

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 8 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) (Last) Wilt			4. DATE OF DEATH (Month) 5 (Day) 16 (Year) 1949		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 10-13-1862	9. AGE last birthday 86 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bittinger Garett Co-Md	12. CITIZEN OF WHAT COUNTRY? U-51	
13. FATHER'S NAME HENRY PLATTER			14. MOTHER'S MAIDEN NAME RACHEL BITTINGER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —	16. SOCIAL SECURITY No. None		17. INFORMANT Mrs John R. Jones		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Degeneration, — One year.

433.1 Antecedent cause(s) (b) Aricular Fibrillation.

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio Schlerosis.,

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1949, to May 16, 1949, that I last saw the deceased alive on May 15, 1949, and that death occurred at 4pm m., from the causes and on the date stated above.

SIGNATURE James H Wolcott (Degree or title) H M — ADDRESS Piedmont W Va. — DATE SIGNED 5/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-19-1949	NAME OF CEMETERY OR CREMATORY Frankville	LOCATION (City, town, or county) (State) Frankville Garett Co Md
DATE REC'D BY LOCAL REG. May 18/49	REGISTRAR'S SIGNATURE [illegible]	24. FUNERAL DIRECTOR Wm Winterberg	ADDRESS Grantsville Md

Wm Winterberg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAY 20 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

04386

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 95 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 119 South Lee St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 119 South Lee St.

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) J (Last) Young

4. DATE OF DEATH: (Month) May (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1854?

9. AGE last birthday: 95 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Johnson Johnson

14. MOTHER'S MAIDEN NAME: Abbie Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: A niece

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Mesenteric carcinoma — ?

158
46 fv

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H V Deming MD. Cumberland Md. May 15-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 18 49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county): Cumberland — (State): Md

DATE REC'D BY LOCAL REG.: May 18, 1949 — REGISTRAR'S SIGNATURE: C.R. Fantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc., — ADDRESS: Cumberland Md.

VS. A15A

RECEIVED
MAY 25 1949
BUREAU V. S.